Arizona School for the Arts
A COLLEGE PREPARATORY AND PERFORMING ARTS TRADITION

Medical Certification of Student with Health Condition

Student's Name:	**Grade**
Address:	**DOB**
Parent/Guardian's Name:	**Phone numbers**
Parent/guardian's email:	

The following information needs to be completed by a licensed medical doctor, podiatrist, osteopathic physician, naturopathic physician, or nurse practitioner.

Diagnosis: _____

Initial date of diagnosis: _____

Please only check if the diagnosis is due to: ☐ Injury ☐ Chronic Illness (please complete the questions on Page #2)

** Please initial if the student's condition is permanent ** _____

Identify limitations affecting school activities:_____

_____

_____

Physical activity limitations:_____

_____

_____

This student may be unable to attend regular classes for intermittent period of one or more consecutive days because of the illness, disease, or accident.
I expect the student's duration of irregular attendance will be _____, if not permanent.

(Form continued on other side)

Complete only if the Chronic Illness Box is selected on Page #1

The undersigned certifies that the patient named above is a chronically ill individual because he or she meets one or more of the following tests (check each test that is met):

☐ Activities of Daily Living Test. The student is unable to perform, without substantial assistance from another individual, at least two of the following activities of daily living (ADL's): eating, toileting, transferring, bathing, dressing, and continence. He or she has been or in the immediate future will be unable to perform such ADL's without such assistance for a period of at least 90 days due to a loss of functional capacity.

☐ Severe Cognitive Impairment Test. The student requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

☐ Chronic Health Condition Test. The student doesn't require homebound instruction, but is unable to attend regular classes intermittent periods of one or more consecutive days because of illness, disease, or accident as certified by a health professional who is licensed pursuant to title 32.

☐ Chronic Health Management Test. The student suffers from a condition requiring management on a long-term basis by a certified health professional who is licensed pursuant to title 32.

I hereby certify this student has the diagnosis health condition listed on the form.

Print Healthcare Provider's Name	
Licensed Title	
Healthcare Provider's Signature	
Date	
Healthcare Provider's phone#	
Healthcare Provider's email	